

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05974

Reg. Dist. No. 116

1. PLACE OF DEATH:

County.....**Dorchester**
City or town.....**Cambridge**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....**1 Yr. 7 Mo. 12 days.**
Hospital, institution, or street address where death occurred:
Eastern Shore State Hosp.
How long in hospital or institution?.....**1 Yr. 7 Mo. 12 Days.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....**Maryland** County.....**Dorchester**
City or town.....**Cambridge**
(If outside city or town limits, write RURAL and give nearest town)
Street No.....**R. D. #2**
(If rural, give LOCATION)
2.(a) If veteran, name war.....**No**

3. (a) FULL NAME

Joseph Washington Ashmead

3. (b) Social Security Number

None

4. Sex.....**Male** 5. Color or race.....**White** 6.(a) Single, married, widowed, or divorced.....**Single**
6.(b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.).....**July ? 1868** 6.(c) If alive, give age..... years
8. AGE: Years.....**79** Months.....**?** Days.....**?** If less than one day..... hrs. min.

9. Birthplace.....**Smiths Island, Maryland.**
(town, county, and state)
10. Usual occupation.....**Waterman**
11. Industry or business.....**Fishing, oystering**
12. Name.....**Joseph Ashmead,**
13. Birthplace.....**Accomac Co. Virginia**
14. Maiden name.....**Nancy Evans.**
15. Birthplace.....**Smiths Island, Maryland**

16. Informant.....**Hospital record**
Address.....
17. **Burial** Date thereof.....**7 - 22 - 1947**
(Burial, cremation, or removal) Which?..... (month) (day) (year)
Cemetery or crematory.....**Greenlawn**
Location.....**Cambridge Md**
18. Funeral director.....**Kenneth R. Thomas**
Address.....**Cambridge, Md**
19. **7-22** 19**47** John Mace, Jr. M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**July 19,** 19**47**, at **2:30 P. M**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 7, 19**45**, to **July 19,** 19**47**,
and that I last saw him alive on **July 19,** 19**47**.
Immediate cause of death.....**Hypertensive cardio**
renal-vascular disease DURATION
Indef.
Due to.....
Due to.....
Other conditions.....**Cellulitis of both feet.** **4 days**
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

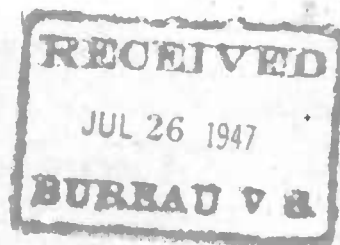
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.....**No** Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE.....**Robert E. Garant** M. D. or other
Address.....**Cambridge, Md.** Date signed **7/19/47**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

05975

1. PLACE OF DEATH:

County DorchesterCity or town Hicksburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Wife

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Hicksburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Otis Askins

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb 4 18848. AGE: Years 63 Months 5 Days 4 If less than one day _____ hrs. _____ min.9. Birthplace Hicksburg Dor Co Md
(Town, county, and state)10. Usual occupation Farming11. Industry or business Farm12. Name Garrison Askins13. Birthplace Dorchester Co Md.14. Maiden name Eliz. Cannon15. Birthplace Hurlock Dor Co. Md16. Informant Helen AskinsAddress Bridgetown Delaware17. Burial Date thereof July 13 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Salem Cem.Location Salem Dor Co. Md18. Funeral director W. M. Bellows & SonAddress Cambridge, Md.19. July 11 1947 John Mace Jr. M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

the year 1947 to 7/4 1947
and that I last saw him alive on 7/7 1947

Immediate cause of death

arterio-sclerotic cerebral
hemorrhage

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE _____

M. D. or other

Address Cambridge, Md.Date signed 7/11-1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

05976

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County Dorchester
 City or town Rhodesdale - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Near Eldorado
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Rhodesdale - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Near Eldorado
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Emily F. Brinsfield

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Daniel H. Brinsfield

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

October 31, 1862

8. AGE:

Years

Months

Days

If less than one day

84824

hrs.

min.

9. Birthplace

Dorchester County, Maryland
(Town, county and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER

12. Name

Jona McAllister

13. Birthplace

Dorchester County, Maryland

MOTHER

14. Maiden name

Ellen Horseman

15. Birthplace

Dorchester County, Maryland

16. Informant

Mrs. Ruth C. Lowe

Address

Rhodesdale, Maryland, R.F.D.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 27, 1947
(month) (day) (year)

Cemetery or crematory

Vienna Cemetery

Location

Vienna, Maryland

18. Funeral director

J. P. Frampton and Son

Address

Federalburg, Maryland

19. Date

July 27, 1947

by registrar

J. P. Frampton
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 25, 1947, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1943 to July 25, 1947
and that I last saw him alive on July 24, 1947

Immediate cause of death

Arterio Sclerosis

DURATION

4 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H. S. Kuhlman

M. D. or other

Address Shampton Md Date signed 7/26/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

05977

1. PLACE OF DEATH:

County... Dorchester
 City or town... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 42 hours, 55 min.
 Hospital, institution, or street address where death occurred:
Cambridge-Maryland Hospital
 How long in hospital or institution? 42 hours, 55 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Dorchester
 City or town... East New Market, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Barbara Elizabeth Bryant

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Eugene

7. Birth date of deceased (mo., day, yr.)

July 15, 1947

6. (c) If alive, give age

42 hours, 55 min.

8. AGE:

Years

Months

Days

If less than one day

118 hrs. 55 min.

9. Birthplace

Cambridge-Maryland Hospital
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name

Kellace Floyd Bryant

13. Birthplace

Nashington, D.C.

MOTHER

14. Maiden name

Marysiet Elizabeth Lichti

15. Birthplace

Hawaii

16. Informant

Marysiet Elizabeth Bryant

Address

East New Market, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

7-19-47
(month) (day) (year)

Cemetery or crematory

Greenlawn

Location

Cambridge, Md

18. Funeral director

Leuneth P. Shuman

Address

Cambridge, Md

19.

(Date rec'd by registrar)

July 20 - 1947John Macfarlane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 16,19 47at 2:51 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1519 47to July 1619 47and that I last saw her alive onJuly 16,19 47

Immediate cause of death

Prematurity and Immaturity
Due to 30-32 weeks gestation

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. O. Meredith, M.D.

M. D. or other

Address

Cambridge, MarylandDate signed July 16, 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

05978

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day, 11 hours, 43 minutes
 Hospital, institution, or street address where death occurred:
Cambridge - Maryland Hospital
 How long to hospital or institution? 1 day, 11 hours, 143 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town East New Market
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Katherine Antoinette Bryant

3. (b) Social Security Number

| | | |
|---|--|--|
| 4. Sex <u>Female</u> | 5. Color or race <u>White</u> | 6.(a) Single, married, widowed, or divorced <u>Single</u> |
| 6.(b) Name of husband or wife <u>Infant</u> | | |
| 6.(c) If alive, give age _____ years | | |
| 7. Birth date of deceased (mo., day, yr.) <u>July 15, 1947</u> | | |
| 8. AGE: | Years | Months |
| | | Days |
| | | If less than one day |
| | | <u>11 hrs. 43 min.</u> |
| 9. Birthplace <u>Cambridge, Maryland Hospital</u> (Town, county, and state) | | |
| 10. Usual occupation <u>Infant</u> | | |
| 11. Industry or business | | |
| FATHER | 12. Name <u>Wallace Floyd Bryant</u> | |
| | 13. Birthplace <u>Washington, D. C.</u> | |
| | 14. Maiden name <u>Margaret Elizabeth Light</u> | |
| MOTHER | 15. Birthplace <u>Holbrook</u> | |
| | 16. Informant <u>Margaret Elizabeth Bryant</u> Address <u>East New Market, Maryland</u> | |
| 17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>7-19-47</u> (month) (day) (year) | | |
| Cemetery or crematory <u>Greenlawn</u> | | |
| Location <u>Cambridge Md.</u> | | |
| 18. Funeral director <u>Kenneth R. Thomas</u> Address <u>Cambridge Md</u> | | |
| 19. <u>July 20</u> 19 <u>47</u> <u>John MacEachron</u> Registrar (Date rec'd by registrar) | | |

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 16, 1947 and that I last saw her alive on July 16, 1947

Immediate cause of death _____ DURATION _____

Prematurity and immaturity
 Due to 30-32 weeks gestation

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE L. O. Meredith, M.D. M. D. or other _____
 Address Cambridge, Maryland Date signed July 16, 1947

STANDARD TELEPHONE AND TELEGRAPH COMPANY

STANDARD TELEPHONE AND TELEGRAPH COMPANY

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JUL 23 1947
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Evidence for the change of

age and birthdate is shown MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05979

on:

FILM No. G 111 JUL 30 1947

FILM No. G 113 DEC 5 - 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 Years

Hospital, institution, or street address where death occurred:

Cambridge Maryland Hospital

How long in hospital or institution? One Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Dorchester

City or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 404 Peachblossom Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roland Coursey Byran

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Pearl Travers

7. Birth date of deceased (mo., day, yr.)

Sept. 24, 1894 ~~1893~~

6.(c) If alive, give age 46 years

8. AGE:

Years

Months

Days

If less than one day

38

5/4

10

19

hrs.

min.

9. Birthplace

Federalsburg, Maryland

(Town, county, and state)

10. Usual occupation

Type Setter

11. Industry or business

Newspaper

FATHER
MOTHER

12. Name

Roland Byran

13. Birthplace

Caroline County, Md.

14. Maiden name

Dill

15. Birthplace

Maryland

16. Informant

Mrs. Pearl Byran

Address

Cambridge, Maryland.

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof July 24, 1947
(month) (day) (year)

Cemetery or crematory

Greenlawn Cemetery

Location

Cambridge, Maryland.

18. Funeral director

LeCompte's Funeral Service

Address

Cambridge, Maryland.

19.

7/24/47
(Date rec'd by registrar)

19.

47 John Mass Jr. MD
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21, 1947 at 10: P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 1947 to July 21, 1947
and that I last saw him alive on July 21, 1947

Immediate cause of death

Coronary Thromboses, acute 3 Days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

W. Thompson M.D.
Address Cambridge, Md. Date signed July 24, 47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 26 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05980

Reg. Diat. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 MonthsHospital, institution, or street address where death occurred:
Cambridge Maryland HospitalHow long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural-Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD # 1
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Charles DE Marteleire

3. (b) Social Security Number

| | | |
|-----------------------|----------------------------------|---|
| 4. Sex <u>Male</u> | 5. Color or race <u>White</u> | 6.(a) Single, married, widowed, or divorced <u>Widowed</u> |
|-----------------------|----------------------------------|---|

6.(b) Name of husband or wife Mary L. Fallon
(Died 6/16/1942)7. Birth date of deceased (mo., day, yr.) Sept. 6, 1890

| | | | | |
|---------|-----------|-----------|----------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | <u>56</u> | <u>10</u> | <u>3</u> | <u>hrs. min.</u> |

9. Birthplace Patterson, New Jersey
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Not Known13. Birthplace "14. Maiden name Not Known15. Birthplace "16. Informant Mrs. Margaret SlacumAddress RFD # 1, Cambridge, Maryland.17. Burial Date thereof July 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Cambridge, Maryland18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. July 10, 1947 John Macaugh Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947 at 7:50A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 1947 to July 9, 1947 and that I last saw him alive on July 9, 1947

Immediate cause of death

DURATION

Myocardial failure 1 dayDue to arterio sclerotic nephritis unknownDue to Hypertension, essential unknownOther conditions arterio sclerotic H.D. unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

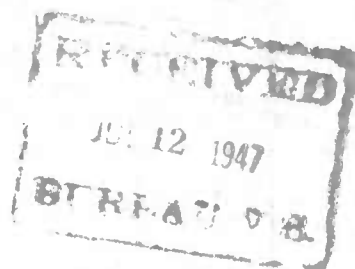
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Lawrence H. H. H. M. D. or otherAddress Cambridge, Md Date signed July 10, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310 1312

05981

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
City or town Rural-Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Month
Hospital, institution, or street address where death occurred:
RFD # 3
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Rural-Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD # 3
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME

Sarah Elizabeth Wroten Edger

3. (b) Social Security Number

-

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Geo. W. Wroten (10/17/1924)

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1860. 6.(c) If alive, give age - years

8. AGE: Years 87 Months 5 Days 29 If less than one day - hrs. - min.

9. Birthplace Dorchester County, Maryland.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Home

12. Name Samuel M. Kirwin

13. Birthplace Maryland.

14. Maiden name Elizabeth Ann Mace

15. Birthplace Maryland

16. Informant Mrs. Tilden Rue

Address RFD 3, Cambridge, Maryland.

17. Burial Date thereof July 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. July 18, 1947 John Mace Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1947 to July 14, 1947
and that I last saw her alive on July 13, 1947
Immediate cause of death Myocardial - Renal - Vascular - Syndrome

Due to Myocardial - Renal - Vascular - Syndrome
Due to -
Other conditions Cholelithiasis
(Include pregnancy within 3 months of death)
Major findings of operations - Date of op. -
Autopsy results -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?) -
Means of injury - injured at work? -

23. SIGNATURE Dr. K. Shriver M. D.
Cambridge - Md. Date signed July 16/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Driver

RECEIVED
JUL 17 1947
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MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

05988

1. PLACE OF DEATH: Dorchester
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....14 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....md. County.....Dorchester
 City or town.....Secretary
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME
Robert Plummer Elliott

3. (b) Social Security Number

214-07-8910

4. Sex.....Male 5. Color or race.....white 6. (a) Single, married, widowed, or divorced.....married

8. (b) Name of husband or wife.....Elizabeth Matilda Elliott

7. Birth date of deceased (mo., day, yr.).....Mar. 25, 1883 6. (c) If alive, give age.....55 years

8. AGE: Years.....64 Months.....3 Days.....27 If less than one day.....hrs. min.

9. Birthplace.....Church Hill, Queen Anne's Co., Md.
 (Town, county and state)

10. Usual occupation.....Painter

11. Industry or business.....

FATHER 12. Name.....John Elliott

13. Birthplace.....Queen Anne's Co., Md.

MOTHER 14. Maiden name.....Elizabeth Dreyer

15. Birthplace.....Queen Anne's Co., Md.

16. Informant.....Mrs. Robert P. Elliott

Address.....Secretary, Md.

17. Burial, cremation, or removal. Which?.....Burial Date thereof.....July 25, 1947
 (month) (day) (year)

Cemetery or crematory.....Spring Hill

Location.....Easton, Md.

18. Funeral director.....Maurice E. Newman, Inc.

Address.....Easton, Md.

19. July 26 - 1947 Charles Hastings
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 22, 1947 at.....47 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....June 47 to.....July 22, 1947

and that I last saw him alive on.....July 18, 1947

Immediate cause of death.....Coronary Thrombosis DURATION.....minutes

Due to.....Chronic Myocarditis 1 yr. +

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....W. Harrison M. D. or other

Address.....Howell, Md. Date signed.....7/24/47

RECEIVED
AUG 6 1947
BUREAU V B



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

05983

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? several years
 Hospital, institution, or street address where death occurred:
Cambridge-Maryland Hospital
 How long in hospital or institution? about 1/2 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 432 Pine St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ray Ennals

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
 B.(b) Name of husband or wife Nellie ?
 7. Birth date of deceased (mo., day, yr.) May 15, 1920 6.(c) If alive, give age 25 ? years
 8. AGE: Years 27 Months 2 Days 4 If less than one day
hrs.min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business ?
 FATHER 12. Name John Ennals
 13. Birthplace Maryland
 MOTHER 14. Maiden name Essie ?
 15. Birthplace Maryland

16. Informant Hospital records
 Address Cambridge, Md.
 17. Burial Date thereof July 21/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Bethel
 Location Cambridge, Md.
 18. Funeral director James H. Bayne
 Address Cambridge, Md.
 19. July 22 - 47 Registrar John H. Shivers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 19 1947 at 12-30A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

X X 19....., to X X 19.....and that I last saw h. X alive on X X 19.....Immediate cause of death HaemorrhageDURATION
1/2 hr.Due to Pistol shot wound of
Liver

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of July 18/47Where did injury occur? Cambridge - Dorchester- Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) on Pine St., nrMeans of injury Pistol shot Injured at work? no23. SIGNATURE Dr. H. Shivers, Dep. Med. Exam.

M. D. or other

Address Cambridge, Maryland Date signed July 19/47

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JUL 23 1947
REFERENCE 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05984

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Ca. bridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 7 mos. 9 ds
 Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital
 How long in hospital or institution? 1 year 7 mos. 9 ds.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne
 City or town Millington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Edward Everett

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 1 1870
 8. AGE: Years 77 Months 1 Days 19 It less than one day _____ hrs. _____ min.

9. Birthplace Queen Anne Cy. Maryland
 (Town, county, and state)

10. Usual occupation Horse trainer

11. Industry or business _____

12. Name Levi Everett
 13. Birthplace Queen Anne County Maryland
 14. Maiden name Becky Peters
 15. Birthplace Queen Anne Cy. Maryland

16. Informant Hospital Records

Address Cambridge, Maryland

17. Burial Date thereof July 23, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hampeville

Location Hampeville Md.

18. Funeral director Edmund J. Lowe

Address Millington Md.

19. July 21 - 19 47 John MacGowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 47 at 8.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 12 19 45 to July 20 19 47
 and that I last saw him alive on July 18 19 47

Immediate cause of death _____ DURATION _____

Bronchopneumonia 1 day

Due to Chronic Myocarditis and Myocardial

Due to Degeneration

Other conditions Arteriosclerosis Hemiplegia

Psychosis with Cerebral
 (Include pregnancy within 3 months of death)
Arteriosclerosis

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John MacGowan M. D. or other _____

Address Cambridge, Maryland Date signed 7/20/47

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JUL 23 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 118

1. PLACE OF DEATH:

County WorcesterCity or town Vienna

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Vienna

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Evelyn S. Fries

3. (b) Social Security Number

None4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife William G. Fries7. Birth date of deceased (mo., day, yr.) Aug. 25 18986. (c) If alive, give age 58 years8. AGE: Years 48 Months 10 Days 15 If less than one day9. Birthplace Orford, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Lake Smith13. Birthplace Orford, Md.14. Maiden name Sarah Stewart15. Birthplace Orford, Md.16. Informant William G. FriesAddress Orford, Md.17. Burial Date thereof July 11 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Orford CemeteryLocation Orford, Md.18. Funeral director Maurice E. Newman, Inc.Address Boston, Md.19. July 11 19 47 Charles H. Fries

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 47 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 JUNE 19 47 to 9 JULY 19 47and that I last saw him ER alive on 7 JULY 19 47Immediate cause of death CARCINOMA OF STOMACH

DURATION

Due to

Due to

Other conditions ARTHRITIS

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

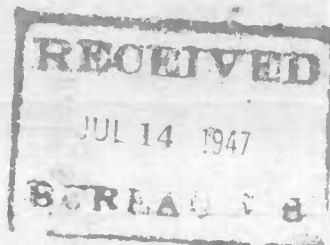
(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Walter E. Smith, M.D.Address 105 CHURCH ST.CAMBRIDGE, MD. Data signed 9 JULY 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05986

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

238 Race St.How long in hospital or institution? 5½ Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 238 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marcus A. Glover

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Illa M. GloverDied 8/2/1941)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1860

8. AGE:

Years

Months

Days

If less than one day

86725

hrs.

min.

9. Birthplace Dorchester County, Maryland.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Not Known

13. Birthplace

II

MOTHER

14. Maiden name

Not Known

15. Birthplace

IIII16. Informant Mrs. Mattie MerrickAddress Cambridge, Maryland.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 17, 1947

(month) (day) (year)

Cemetery or crematory Cambridge CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. July 16, 1947

Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on July 14, 1947

Immediate cause of death

arteriosclerosis

DURATION

Due to

Due to

Other conditions

hypertension degeneration

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gay Smith

M. D. or other

Address

Cambridge, Md.

Date signed

7/16-1947

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JUL 17 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 059871

1. PLACE OF DEATH:

County Dorchester
City or town Rhodesdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alpheus Harper

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 1st 1879 6. (c) If alive, give age years

8. AGE: Years 68 Months 4 Days 2nd If less than one day hrs. min.

9. Birthplace Farmer (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William H. Harper

13. Birthplace Farmer

14. Maiden name Nancy C. Hunt

15. Birthplace

16. Informant Mrs Alpheus Harper

Address Rhodesdale

17. Burial (Burial, cremation, or removal, Which?) Buried Date thereof July 30 1947 (month, day, year)

Cemetery or crematory Greenwood

Location Harlock

18. Funeral director G. B. Thibault

Address East New Market

19. July 30 1947 Elizabeth C. Smith Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Dorchester
City or town Rhodesdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28th 1947 to July 27th 1947

and that I last saw him alive on July 27th 1947

Immediate cause of death Uremia

Due to Cardio-Vascular

Due to Renal Disease

Due to Complicated by Diabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury injured at work?

23. SIGNATURE W. E. Egan MD M. D. or other

Address Frederick MD Date signed July 29th

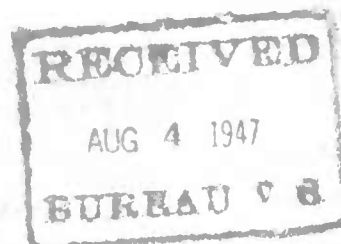
DURATION
14 days

1934

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 306

05988

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County..... **Dorchester**
 City or town..... **Cambridge**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **6 mos. 6 ds.**
 Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital
 How long in hospital or institution?..... **6 mos. 6 ds.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Wicomico**
 City or town..... **Salisbury**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **223 South Division St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ringgolg B. Jackson

3. (b) Social Security Number

none

4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Widowed**
 6. (b) Name of husband or wife..... **unknown**
 7. Birth date of deceased (mo., day, yr.)..... **Sept. 28 1873**
 8. AGE: Years..... **73** Months..... **9** Days..... **29** If less than one day..... hrs. min.

9. Birthplace..... **Wicomico County, Maryland**
 (Town, county, and State)
 10. Usual occupation..... **Painter**
 11. Industry or business.....

12. Name..... **unknown**
 13. Birthplace.....
 14. Maiden name..... **Annie Virginia Streett**
 15. Birthplace..... **unknown**

16. Informant..... **Hospital Records**
 Address..... **Cambridge, Maryland**

17. Burial..... **Buried** Date thereof..... **July 29-47**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Traskin Md.**
 Location..... **Traskin Md.**
 18. Funeral director..... **John R. Hall**
 Address..... **Salisbury Md.**

19. **7-28-47** 19 **47** **John Mass. Jr. MD.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **July 27** 19 **47** at **7:30A**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 20 19 **47** to **July 27** 19 **47**
 and that I last saw him alive on **July 25** 19 **47**

Immediate cause of death..... **Arteriosclerotic cardiovascular disease**
 DURATION..... **unknown**

Due to.....
 Due to.....

Other conditions..... **Paresis**
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **John R. Hall** M. D. or other
 Address..... **Cambridge** Date signed..... **7/27/47**

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JUL 29 1947
BUREAU OF

that this death due to
senile paresis or
general paralysis of
the insane.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

CERTIFICATE OF DEATH

05989

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Chap
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Chap
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race Caucasian 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Clairne V. Gahson7. Birth date of deceased (mo., day, yr.) 31 March 1893 6. (c) If alive, give age 38 years8. AGE: Years 44 Months 4 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Chapale not
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Gabe Gahson13. Birthplace Chapale14. Maiden name Ennis Barker15. Birthplace Dorchester16. Informant Meritt G. GahsonAddress Chapale17. Beach Grove Date thereof July 22

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ChapaleLocation 118. Funeral director Levin H. BermanAddress Cambridge19. July 22 47 Registrar John Macfarlane

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 47 at 2:22 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Ca. Sudden death 2 mo.Starvation 2 weeksDue to Paralysis of medullaCentrifugal vascular collapseDue to Myocardial vascular collapseCa. Sudden deathOther conditions general

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Thompson M. D. or other _____Address Chapale Date signed July 22/47

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JUL 23 1947
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05990

Reg. Dist. No. 116

1. PLACE OF DEATH

County Dorchester
 City or town Cambridge Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Charles St
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Josiah Jones

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Elaine Jones

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1892 6.(c) If alive, give age..... years

8. AGE: Years 55 Months 3 Days 6 If less than one day..... hrs. min.

9. Birthplace Worcester Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Jones
 13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Anna Travers
 15. Birthplace Worcester Island

16. Informant Elaine Jones
 Address Cambridge Md

17. Burial Date thereof 8/8/47
 (Burial, cremation, or removal of body) (month) (day) (year)

Cemetery or crematory Worshipful
 Location Worshipful

18. Funeral director J. W. Bayrum
 Address Cambridge Md.

19. 7-8-47 John M. Jones Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 5 1947 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1947, to July 5 1947, and that I last saw him alive on July 5 1947.

Immediate cause of death Carcinoma of the Prostate Gland DURATION 7 mo.

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

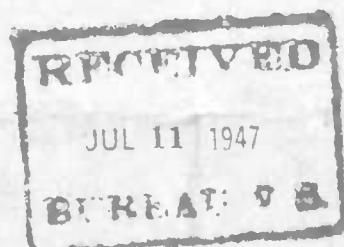
Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE P. H. Tarace M. D. or other
 Address Cambridge Md Date signed July 8, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05991

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:
County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 26 days
Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital
How long in hospital or institution? 1 yr. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town East New Market
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3. (a) FULL NAME

Samuel A. Jones

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife ---
6.(c) If alive, give age --- years
7. Birth date of deceased (mo., day, yr.) February, 1870
8. AGE: Years 77 Months 5 Days --- If less than one day --- hrs. --- min.
9. Birthplace East New Market, Dorchester Co., Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business ---

12. Name Dr. George Jones
13. Birthplace Princess Anne, Md.
14. Maiden name Wilhelanne Austin
15. Birthplace unknown

16. Informant Eastern Shore State Hospital Records!
Address Cambridge, Maryland

17. Burial Date thereof 7/31/47
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cemetery
Location East New Market, Md.

18. Funeral director Ruth S. Hillooughby
Address East New Market, Md.

19. 7/28/47 19 47 John Mace
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 47 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 46 to July 28 19 47
and that I last saw him alive on July 28 19 47

Immediate cause of death Chronic Myocarditis and Myocardial Degeneration

Due to Senility

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury --- Injured at work? ---

23. SIGNATURE Grace M. Branscombe, M.D.

Address Eastern Shore State Hos. Date signed 7-28-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
JUL 31 1947
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

05992

115

1. PLACE OF DEATH:

County LO Ouchester

City or town FISHING CREEK
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Slay in hospital or inst. (yrs., or mos., or days) none

Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County LO Ouchester

City or town Fishing Creek
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____ (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME

EFFIE - INELL - MEEKINS.

3. (b) Social Security Number

none

4. Sex Female

5. Color or race white

6. (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife George Dewey Meekins

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) June 15 - 1908

8. AGE: Years 39 Months 1 Days 9 It less than one day _____ hrs. _____ min.

9. Birthplace Mellottuck, W. Va.
(Town, county, and state)

10. Usual occupation house wife

11. Industry or business own home

12. Name Sawson Hale - HALE

13. Birthplace Virginia

14. Maiden name Alice Inell-Hale

15. Birthplace Virginia

16. Informant George Meekins

Address Fishing Creek, Md.

17. Burial Date thereof July 26 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Howe Memorial Cemetery

Location Fishing Creek, Md.

18. Funeral director Seacombe Funeral Service

Address Cambridge, Md.

19. July 26 19 47 James W. Meade
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 47, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 23 19 46, to July 24 19 47, and that I last saw her alive on July 22 19 47.

Immediate cause of death _____

Carcinoma of Uterus

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings: _____

Di operations _____

Di autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James W. Meade M.D.

Address Fishing Creek, Md. Date signed July 25/47

DURATION

18 mos.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

05993

CERTIFICATE OF DEATH

Reg. Dist. No. 118

1. PLACE OF DEATH:

County Dorchester
 City or town Rural-Toddville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Toddville
 How long in hospital or institution? - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Rural-Toddville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. T oddville
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

Connor S. Meredith

3. (b) Social Security Number

-

| | | |
|--|----------------------------------|--|
| 4. Sex <u>Male</u> | 5. Color or race <u>White</u> | 6. (a) Single, married, widowed, or divorced <u>Married</u> |
| 6. (b) Name of husband or wife <u>Maggie Bell</u> | | |
| 7. Birth date of deceased (mo., day, yr.) <u>Feb. 12, 1876</u> | | |
| 6. (c) If alive, give age <u>64</u> years | | |
| 8. AGE: Years <u>71</u> | Months <u>5</u> | Days <u>17</u> hrs. min. |

9. Birthplace Toddville, Dor. Co., Md.
(Town, county, and state)10. Usual occupation Ship Carpenter11. Industry or business Ship Building12. Name John L. Meredith13. Birthplace Maryland14. Maiden name Hester Cannon15. Birthplace Maryland16. Informant Mrs. Maggie B. MeredithAddress Toddville, Maryland.17. Burial Date thereof July 31, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dorchester Memorial ParkLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 7-31- 19 47 John Mace Jr. mdr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 47 at 2:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 47and that I last saw him alive on July 28, 1947Immediate cause of death Coronary Occlusionwith peripheral vessel collapseDue to Hypertension C.V.D.Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE W. Thompson M.D.Address Cambridge, Md. Date signed July 31/47

RECEIVED
AUG 4 1947
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 05998

1. PLACE OF DEATH:

County Dorchester
City or town Rhodesdale - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Near Eldorado
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Rhodesdale - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Eldorado
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Cora H. Payne

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Walter Benjamin Payne
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 5, 1863
8. AGE: Years 84 Months 0 Days 19 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 47 at 2:05 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 47 to July 24 19 47
and that I last saw him alive on July 23 19 47

Immediate cause of death Cerebral Hemorrhage DURATION 18 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE J. F. W. Kuhlman M. D. _____

Address Shampton Rd Date signed 7/24/47

9. Birthplace Dorchester County, Maryland
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business None
12. Name William J. Hurlock
13. Birthplace Dorchester County, Maryland
14. Maiden name Mahaley Thomas
15. Birthplace Dorchester County, Maryland
16. Informant Mrs. Osborne Marine
Address Rhodesdale, Maryland, R.F.D.
17. Burial Date thereof July 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Eldorado Cemetery
Location Eldorado, Maryland
18. Funeral director J. F. Trampton and Son
Address Federalsburg, Maryland
19. July 27 19 47 H. G. Hastings Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 6 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05995

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
City or town Rural-Toddville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Toddville
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Rural-Toddville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Toddville
(If rural, give LOCATION)
2.(c) If veteran, name war -

3. (a) FULL NAME

James Milton Robinson

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Virginia F. Robinson
(Died 5/30/1925) 6.(c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) July 20, 1862
8. AGE: Years 85 Months - Days 4 If less than one day - hrs. - min.

9. Birthplace Toddville, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation Waterman-Farmer

11. Industry or business Retired

12. Name Slater Robinson

13. Birthplace Maryland

14. Maiden name Mary Jones

15. Birthplace Maryland

16. Informant Mr. Preston Robinson

Address Toddville, Maryland

17. Burial Date thereof July 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion M. E. Cemetery

Location Toddville, Maryland

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland

19. 7-26-47 John M. E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 47 at 10: A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 19 47 to July 17 19 47
and that I last saw him alive on July 17, 1947

Immediate cause of death known - myo-carditis
DURATION 6 mo

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE P. H. Jones M. D. or other -

Address Cambridge, Md Date signed 7/25/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 29 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

05996

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cambridge Maryland Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty DorchesterCity or town Rural-Toddville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Toddville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Willis James Robinson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 9, 1910

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

3717

hrs.

min.

9. Birthplace

Toddville, Dor. Co., Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

William O. Robinson

13. Birthplace

Maryland

14. Maiden name

Bessie Hoffman

15. Birthplace

Maryland

16. Informant

Mr. W. O. RobinsonAddress Toddville, Dor. Co., Md.

17.

Burial

Date thereof

July 17, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Zion Church Cemetery

Location

Toddville, Maryland.

18. Funeral director

LeCompte's Funeral Service

Address

Cambridge, Maryland.

19.

(Date rec'd by registrar)

18

7/17/47 John McKee Jr. M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 JUNE1947to 15 JULY1947and that I last saw him alive on 15 JULY 19 47Immediate cause of death ACUTE
CONGESTIVE CARDIAC
FAILURE

DURATION

Due to

Due to

Other conditions

UREMIA: Cause undeterminedPatient on 3 trials during 2 mo. before death had

(Include pregnancy within 3 months of death)

"doubtful positive" blood syphilis test [9/17/47 obs]

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

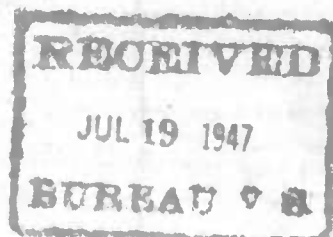
Injured at work?

SIGNATURE

Walter E. McKee, M.D.

M.D. or other

Address 105 CHURCH ST.
CAMBRIDGE, MD.Date signed 16 July 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05997

116

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months 29 days

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution? 2 months 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Crisfield
(If outside city or town limits, write RURAL and give nearest town)Street No. R. F. D. # 2
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Marion T. Ross

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

white

married

8. (b) Name of husband or wife Mary RossB. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) January 14, 18778. AGE: Years Months Days If less than one day
70 5 30hrs.min.9. Birthplace Pomoke City, Somerset County, Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John Ross13. Birthplace unknown14. Maiden name unknown

15. Birthplace

16. Informant Eastern Shore State Hospital RecordsAddress Cambridge, Maryland17. (Burial, cremation, or removal, Which?) Date thereof January 17, 1947
(month) (day) (year)Cemetery or crematory St. IgnaceLocation St. Ignace18. Funeral director Richard CoringtonAddress 306 Main St. Cambridge19. July 18 19 47
(Date registered by registrar) Registrar Janice E. Spivey

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 47 at 3:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 16 19 47 to July 8 19 47and that I last saw him alive on July 8 19 47

Immediate cause of death..... DURATION

Cerebral Hemorrhage

Due to.....

Cerebral Arteriosclerosis

Due to.....

Other conditions Psychosis withCerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Grace M. Branscombe, M.D. D. or otherAddress Eastern Shore State Hos. Date signed 7-8-47

RECEIVED
JUL 23 1947
BUREAU 58

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05998

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 317 West St
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Almita Eubanks St Clair

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female colored married
 6. (b) Name of husband or wife Herbert M St Clair
 6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct 28 1909
 8. AGE: Years Months Days It less than one day

37 9 15 hrs. min.

9. Birthplace Roswell New Mexico
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Crutcher Eubanks12. Name Almita Eubanks13. Birthplace Blossum Kentucky14. Maiden name Mary Beauchamp15. Birthplace Edmonton Ky16. Informant Paul McDonaldAddress Albuquerque New Mexico17. Burial Date thereof July 17 1947
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Woods CemeteryLocation Cambridge Md18. Funeral director H. M. Bell & SonAddress Cambridge Md19. July 16 - 1947 John Macfarland
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that, attended deceased from

April 4 1947 to July 13 1947and that I last saw him alive on July 13 1947Immediate cause of death Carcinoma LungDue to Carcinoma BreastDue to 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations CarcinomaLeft Breast Date of op. 4/15/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Carroll M St-Clair MD

M. D. or other

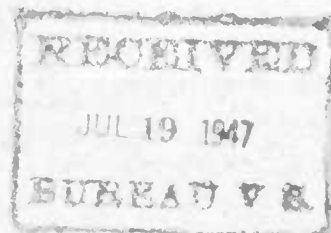
Address On Red St Date signed 7/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

05999

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County..... Dorchester
 City or town..... Reid's Grove
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... all of life
 Hospital, institution, or street address where death occurred:
on State Road
 How long in hospital or institution?..... X

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Dorchester
 City or town..... Reid's Grove
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... X
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Elwood Junior Smullens or Smullers3. (b) Social Security Number
None

4. Sex..... male 5. Color or race..... colored 6.(a) Single, married, widowed, or divorced..... single
 6.(b) Name of husband or wife..... X
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... December 16, 1945
 8. AGE: Years..... 1 Months..... 7 Days..... 11 If less than one day..... hrs. min.

9. Birthplace..... Dorchester County, Md.
 (Town, county, and state)
 10. Usual occupation..... none
 11. Industry or business..... X
 12. Name..... Elwood Dennis
 13. Birthplace..... Md.
 14. Maiden name..... Juanita Smullens
 15. Birthplace..... Md.

16. Informant..... Elwood Dennis
 Address..... Reid's Grove, Md.

17. Burial Date thereof..... July 23, 1947
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Reid's Grove Cemetery
Reid's Grove, Maryland
 Location.....
 18. Funeral director..... J. J. Frampton and Son
 Address..... Federalburg, Maryland

19. Date rec'd by registrar..... July 23 - 1947 Registrar..... Charles W. Hastings

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 21 19..... 47 at..... 1-45P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....
 X..... 19....., to..... X..... 19.....
 and that I last saw him..... X..... alive on..... X..... 19.....

Immediate cause of death..... Injury to brain
 DURATION..... X

Due to..... Fracture of SkullDue to..... Brain cavity entirely emptiedOther conditions..... X

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Accident Date of..... July 21/47

Where did injury occur?..... Reid's Grove - Dor. - Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... on State RoadMeans of injury..... Automobile Injured at work?..... no

23. SIGNATURE..... Jon. K. Shivers, Dep. Med. Exam
 M. D. or other

Address..... Cambridge, Md. Date signed..... July 21/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 060076

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Centre Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Centre Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clair Spicer
 4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife Samuel Spicer 6.(c) If alive, give age 18.80 years
 7. Birth date of deceased (mo., day, yr.) Mar 22

8. AGE: Years 67 Months 4 Days 18 If less than one day hrs. min.

9. Birthplace Lak Hill Md
 (Town, county, and state)

10. Usual occupation Lab-aer

11. Industry or business me

12. Name Jam Harris
 13. Birthplace Dont know

14. Maiden name Clair Phillips
 15. Birthplace Dont know

16. Informant Julia Anderson
 Address 14 Centre St

17. Linea Road Date thereof July 24
 (Burial, cremation, or removal. Which) (month) (day) (year)
 Cemetery or crematory Linea Road

Location Church Hill Rd
 18. Funeral director Levin H. Berman
 Address Cambridge Md

19. 7/25/47 19 47 John M. ...
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 47 at 5:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 19 46 to July 19 19 47
 and that I last saw him alive on July 19 19 47

Immediate cause of death Ca (abdominal) - T. w. metastases
 DURATION ?

Due to Stomach, pneumonia 3 mos.

Other conditions Stomach, pneumonia 3 mos.
 (Include pregnancy within 8 months of death)

Major findings of operations Stomach, pneumonia 3 mos.

Antemortem results Stomach, pneumonia 3 mos.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

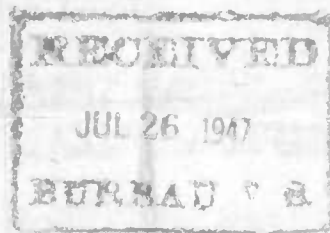
Accident, suicide, or homicide Stomach, pneumonia 3 mos. Date of July 24

Where did injury occur? Stomach, pneumonia 3 mos. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Stomach, pneumonia 3 mos.

Means of injury Stomach, pneumonia 3 mos. Injured at work?

23. SIGNATURE W. Thompson MD M. D. or other MD
 Address Cambridge Md Date signed July 25



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06001

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Rural-Cambridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

RFD # 2

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District Col. County Mont.

City or town Washington Silver Spring Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8428 Pine Branch Court.
(If rural, give LOCATION)

2.(a) If veteran, name war -

3. (a) FULL NAME

Donald Richard Sweetman

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Nina Dean

7. Birth date of deceased (mo., day, yr.) October 26 1895

6.(c) If alive, give age 43 years

8. AGE: Years 51 Months 8 Days 23

If less than one day - hrs. - min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Building

12. Name Michael Sweetman

13. Birthplace Ohio

14. Maiden name Mary T. Nockely

15. Birthplace Ohio

16. Informant Mr. John R. Sweetman

Address 8428 Pine Beach Crt., Wash. D.C.

17. Burial Date thereof July 22, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D. C.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. July 20 47 John Macfarland Registrar

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1947 at 10:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead on arrival

and that I last saw him Dead on arrival

Immediate cause of death Cerebral accident

DURATION

40 min.

Due to -

Due to -

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. -

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of Injury Eldridge H. Hoffmann acting

Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Cambridge, Md. Date signed 7-20-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 22 1947

5 PPA

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06002

Reg. Dist. No. 46

1. PLACE OF DEATH:

County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 224 Robbins St.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Hamale E. Todd

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife James E Todd

7. Birth date of deceased (mo., day, yr.) Aug 5 - 1874 6. (c) If alive, give age 73 years

8. AGE: Years 72 Months 10 Days 25 It less than one day.....hrs.min.

9. Birthplace Dorchester
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Richard Q Todd

12. Name Richard Q Todd

13. Birthplace Dor Co

14. Maiden name Angelene Johnson

15. Birthplace Dor Co

16. Informant Mrs. Boyd Luckey

Address 224 Robbins St. Cambridge Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof July - 3 - 1947
(month) (day) (year)

Cemetery or crematory Todd Family Cemetery

Location Wingate, Ind

18. Funeral director Kenneth R. Johnson

Address Cambridge, Md.

19. 7-3- 47 John Marsh md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 19 47 to July 1 19 47

and that I last saw him alive on July 1 19 47

Immediate cause of death Robert P. Fumoles

DURATION

3 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE P. H. Tavel M. D. or other

Address Cambridge, Md Date signed 7/2/47

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1947

SURFACE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06003

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? All to date
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester
City or town: Cambridge Md
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hubert, n: Vaughan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 30 Dec 1946

8. AGE:

Years: 6 Months: 15 Days: 5 If less than one day
..... hrs. min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name: Waddell Thompson13. Birthplace: York Meck14. Maiden name: Clola Vaughan15. Birthplace: Louisburg NC16. Informant: Clola VaughanAddress: Cambridge Md17. Church Clerk Date thereof: July 24-47
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory: old fieldLocation: Church Clerk18. Funeral director: Levin H. BayneAddress: Cambridge Md19. July 24-47 John M. Bayne
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 47 at 3:30 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 19 47 to July 22 19 47
and that I last saw him alive on July 19 19 47Immediate cause of death: Congestive heart disease DURATION: 6 1/2 mos

Due to:

Due to:

Other conditions: Eczema 3 mos

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert E. Bayne MD M. D. or otherAddress: Cambridge Md Date signed: 7-24-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

